

FAIR HEARING SUMMARY

Appellant:	Mr. Andrew Ditch
DOB:	06/07/1985
Issue:	Denial of Eligibility for Medicaid Services provided through OPWDD
Hearing Date:	September 28, 2021
Prepared By:	Giuseppina Bugenhagen, Western New York Independent Living, Inc. NY Connects Outreach Specialist
FH#:	8121380K
Appellant Rep:	Giuseppina Bugenhagen, (716)836-0822, ext. 121

PRELIMINARY STATEMENT

The New York State Office of People with Developmental Disabilities (“OPWDD”) and its local Western New York Developmental Disabilities Regional Office (“DDRO”), Person Center Services, and Prime Care have improperly advised and directed the Appellant about the complex OPWDD application process. It was the responsibility of these organizations to assist The Appellant with getting the needed medical, mental health, and educational records to submit to OPWDD. The Appellant’s neurodevelopmental disorders have significantly impaired his ability to comprehend the application process, the eligibility criteria for OPWDD services, and how to obtain services. Without the proper assistance, he was unable to secure the crucial records to indicate his developmental disability. Thus, his application process was dragged out for over 3 years, prolonging his ability to receive the entitled services, due in part of negligence and arbitrary approach to the OPWDD application process.

Over the past 3 years, OPWDD has given 25 denial letters to the Appellant (Addendum – OPWDD Denial Letters). Each notification determined his ineligibility was based on an arbitrary application of the criteria and alleged a “lack of qualifying diagnosis AND/OR a lack of substantial handicap attributable to a qualifying diagnosis prior to age 22”. Furthermore, as per the OPWDD April 27, 2021 Fair Hearing Summary, the Agency asked for a “Comprehensive Autism Assessment and a measure of adaptive behavior functioning...A comprehensive autism diagnosis must include measure and narrative that address both developmental information from early childhood, as well as direct observation.”.

When the Agency identified the reasons for ineligibility on the September 24, 2020 OTDA Fair Hearing, an adjournment was requested for the Appellant to secure childhood records, medical and mental health records, and the opportunity to obtain the 11th Comprehensive Autism Assessment/ neuropsychological evaluation. During pandemic, records were requested from 50 plus organization and all the school placements. Unfortunately, many records were not received either due to the records were destroyed (eg: Ken-Ton School District reported that educational records were destroyed.) or there was a lack of response (eg: There were four attempts to contact the local Social Security Administration to secure childhood records and there was no response.). Regardless of the limited responses from the varied organizations, the April 27, 2021 OTDA Fair Hearing Summary for the Appellant had a comprehensive representation of his record. (**PLEASE NOTE:** The OTDA Fair Hearing Summary from April 27, 2021 is resubmitted as an abridge summary of the findings from the voluminous evidence packet.)

It must be noted that there is a gap in the record from the age of 8 ½ years old thru 15 ½ years old. This is significant to note because the Agency keeps referring to only childhood records can indicate a qualifying diagnosis, but the Mental Hygiene Law 1.03(22) clearly indicates provisions in the law such that if clinical records and other historical material are not provided or available that current evaluations can be considered for the qualifying diagnosis and eligibility. Due to this legal parameter, the Appellant pursued an 13th neuropsychological evaluation with Dr. Paul Kopfer. (Attachment - Dr. Kopfer Part I and Part II Report) The Appellant selected Dr. Kopfer because of his extensive professional career working with individuals with Autism and his almost 30 years (from 1982-2011) of working as a psychologist at WNY DDSO on the Eligibility Committee. Even with Dr. Kopfer distinguished professional history, the Agency continues to deny the Appellant eligibility and arbitrarily dismissed the findings of Dr. Kopfer. (Attachment - OPWDD Denial Letters for May 10, 2021, June 10, 2021, and September 19, 2021.). The Agency continues to act in BAD FAITH and has taken advantage of the Appellant’s limitations and disability.

Additionally, within this past year, the Appellant continued to be ineligible for legal representation. Subsequent requests were made to both the Center for Elder Law and Disability Rights of New York for the Appellant, and both organizations have denied him services due to pandemic challenges such as lack of staffing. Due to the lack of legal representation services, the Appellant continued to utilize

Western New York Independent Living, Inc. (“WNYIL”), an Independent Living Center that is a community-based, cross-disability, non-profit organization that is designed and operated by people with disabilities. Without the support of this organization, the Appellant would have continued to flounder through the OPWDD application and appeals process.

The record will show that the Appellant has experienced a continuum of misinterpretations and misdiagnoses by medical professionals, mental health service providers, educational providers, and system professionals. Due to the magnitude errors and multiple diagnoses of professionals, the Appellant has endured prolonged homelessness, lack of medical management of chronic infections and disorders, and lack of appropriate services. The DDRO and OPWDD have used his complex history to confuse the issues and their responsibility in ensuring the Appellant received the highest quality and effective care and treatment. As to the Appellant’s inability to function society, we will let the record speak for itself.

This appeal is the Appellant’s attempt to clarify the record of his medical and mental health issues and advocate for appropriate services to improve his quality of life. The enclosed prior medical documents, mental health treatment and diagnostic documents, neuropsychological reports, and educational documents and subsequent reports of Dr. Kopfer clearly indicate that the Appellant is an individual who is dually diagnosed with a neurodevelopmental disorder of ASD, ADHD, and Tourette’s Syndrome and with comorbid mental health disorders.

OVERVIEW OF SUBMITTED RECORDS

EDUCATION EVALUATIONS AND RECORDS

The Appellant has an extensive special education history. He was receiving services since the age of 3 for his neurodevelopmental disorders including his Mixed Receptive and Expressive Speech and Language disorder. Below is a synopsis of his educational journey from 1988 thru 2005 as captured by Stanley G. Falk records and WNYCPC records. (Addendum Education Section)

YEARS	AGE	DESCRIPTIONS
1988 - 1989	3 years old – 4 years old	The Appellant began his education at the Head Start Program at the age of three . He was classified as speech impaired that resulted in a referral to the Language Development Program (LDP) .
1990 – 1991	5 years old – 6 years old	He attended the LPD from the age of four to six. In 1990, The Appellant was evaluated by Dr. David Kaye at Children’s Hospital and was diagnosed with Adjustment Disorder and Expressive Language Disorder . He was subsequently

		received mental health services at Baker Victory Services. While at LPD, began to show aggressive behaviors towards adults, he was placed in September of 1991 in a 12:1:1 Emotionally Disturbed classroom, in Fletcher Street School in district of Tonawanda.
1992- 1997	7 years old – 12 years old	<p>Due to the a prolonged period of being sexually abused, the Appellant's behaviors and threats of suicidal ideations and gestures increased during this time period. At the age of 7, his first hospitalization at Western NY Children's Psychiatric Center ("WNYCPC") from 9/7/1992 thru 11/25/1992 occurred. (WNYCPC Screening/ Admission Note, and Psychiatric Evaluation dated 11/28/92). It was reported that Appellant's had impulsive and aggressive behaviors in the home, and school setting. His primary diagnosis was Post Traumatic Stress Disorder with an Axis II diagnosis of R/O Language Disorder. At this point you see the language disorder that qualifies as a developmental disability related to his language disorder fade in significance relative to Appellant's other problems. He was discharged to home, remained in WNYCPC's Convalescent Care 11/25/1992 until 3/10/1993, and then returned to SEP-BOCES Program, 3/22-/3/23/1993.</p> <p>The next year Appellant was placed in 6:1:1 SEP-BOCES Program due to aggressive behavior toward adults and peers. Three months later he was transferred into the WNYCPC due to deterioration in behavior. He was then discharged and returned to SEP-BOCES in March of 1993. He was re-hospitalized in June of 1993(age 8) for threatening to kill his mother, and again discharged in September of 1993. A referral was made that Appellant be placed at the Stanley G. Falk School, where he began his placement on 9/9/1993 in a 6:1:1 Classroom.</p> <p>During this hospitalization, psychological and intellectual evaluations occurred by 2 psychologists, Dr. Margorie Warner and Dr. Gary Healey. Their findings are as follows: 1)On the August 17, 1993 Rorschach, an instrument used for psychological functioning, indicated a) There are tendencies of avoidance of complex ideas.; b)He uses practical and concrete facts to process information; c)His processing of information can create problems and misinterpretation of social/environmental cues.; d)He has problems with consistency of thinking that appears like fantasy like thought processes.; e)He creates self-imposed helplessness to ensure dependency on others.; and f)He has severe problems with separating fantasy from reality. This was created by him as a coping skill and avoidance of stress.</p> <p>The WISC-III was also administered by Dr. Gary Healey on 7/7/1993 and the findings are as follows: a)He obtained a Verbal Scale IQ score of 102, Performance Scale IQ score of 110, and Full Scale IQ Score of 106.; b)He would be more responsive to non-verbal stimuli than verbal stimuli.; c)He has difficult processing and reporting information.; c)He has average cognitive ability with a significant discrepancy between his expected reading achievement level to</p>

		<p>actual level of achievement.; d) He has a Specific Developmental Reading Disorder with some evidence of dysgraphia, a neurological disorder indicating spelling and thought process issues.; and e) There was advocacy regarding reclassification to Learning Disabled or Multiple Handicapped.</p> <p>On 9/3/1993, Appellant was discharge from WNYCPC. His prognosis at that time was Axis I – PTSD and Tic Disorder NOS, Axis II – Developmental Reading Disorder, and Axis III – Auto Immune Thyroiditis. Recommendations included a) A follow up with the City of Tonawanda Police Department regarding the sexual abuse incident.; b) Treatment with Peter Leising for trauma.; c) Referral to Intensive Case Management by Mid-Erie.; and d) Referral to Stanley G. Falk.</p> <p>At age 8, the third hospitalization at WNYCPC occurred on 10/7/1993 thru 4/18/1994. The reasons for readmission was a transfer per ambulance from the Buffalo Outpatient Clinic, as it was reported he was having difficulty readjusting to home environment, displaying physical aggression toward family members, threatening to “kill his mother”, and possible adverse effects from medication. It was also reported that Appellant was triggered by seeing his brother who assaulted him. Admitting diagnosis was Axis I-PTSD, ODD, and Axis II – Expressive Language Disorder. During this admission, the need for a long term out of home residential treatment was identified.</p> <p>In Dr. Basilia Bordador’s report on 10/9/1993, she is the first psychiatrist that stated : “Appellant is prone to dissociative episodes under stress and that he has delusional about perpetrator stalking him.”. Even though within the same record Mr. and Mrs. Ditch confirmed that their son was in the vicinity, their statements were minimized and Dr. Bordador’s summary sets the stage for future diagnoses of Psychosis NOS and Schizoaffective Disorder to be pursued. Eventually, Appellant was discharge from WNYCPC’s Convalescent Care on 4/18/1994 to Conner’s Children Center, an out of home children’s group home, in Buffalo, New York.</p> <p>His behavior began to deteriorate again, which resulted in third placement at WNYCPC on 10/7/1993. The Appellant returned to his educational placement at Stanley G. Falk on 10/28/1993 and was discharged from the WNYCPC in January 1994. Appellant returned home to live with parents and younger brother. On 8/7/1994, Appellant began residential placement at Conner’s Children Center and attended a classroom at Delaware Site of Stanley G. Falk School. He was discharged against medical advice on 12/5/1997.</p>
1998-1999	13 years old – 14 years old	<p>The Appellant continued to display behavioral difficulties within the home setting. On 7/9/1998, Appellant was admitted to Brylin Hospital and was discharged home on 8/17/1998. He continued to struggle with attendance in the 1998-1999 school year. Behavioral difficulties continued to occur within the home and school setting, and he continued to escalate in verbal and physical aggression.</p>

		<p>The Appellant continued to display behavioral difficulties within the home setting. Through his educational journey, Appellant struggled academically and with interpersonal relationships due to his behavioral, emotional, cognitive processing, and communication difficulties. It was consistently recommended that he needed 1:1 aide assistance and constant adult supervision. Additionally, it was reported that Appellant's peer interactions were verbally aggressive, sexualized, condescending and inappropriate.</p>
2000-2005	15 years old – 19 years old	<p>During the fall of 2001, Appellant was placed at the Holding center for assaulting his mother and a police officer. He was hospitalized for a 4th time (4/2002-7/2002) at WYNCPC for suicidal gestures and harm in the Holding Center. Eventually, Appellant was discharged back to his home and Stanley G. Falk School.</p> <p>On the 11/29/2001, at the age of 16. Educational Assessment, the <u>Woodcock-Johnson Psycho-educational Battery</u> was administered. The results on that report were a) Reading – He scored 4.6 grade equivalent on Reading Cluster. He scored 5.1 grade equivalents on reading a passage and missing words. The Reading Fluency subtest measure indicated a score of 4.1 grade equivalence on reading sentences and determining statements of true and false.; b) Math – He scored a 7.3 grade equivalence on mathematical computations and 3.8 grade equivalence on solving mathematical equations.; and c) Written Language – He scored a 4.5 grade equivalent for writing clusters and 5.4 on the Spelling subtests. Appellant has difficulty with organizing thoughts and presenting with Attention deficit/hyperactivity disorder (ADHD) writing examples.</p> <p>During his triannual review in 3/4/2002, at the age of 17, the following assessments occurred: <u>Woodcock Johnson Psycho-Educational Battery, and the Behavioral Assessment for Children-Teacher Rating Scale.</u> Appellant functioned below grade level on his Woodcock Johnson Psycho-Educational Battery- III. His scores in Broad Reading: 4.6 grade equivalent; Broad Math: 5.9 grade equivalent, and Broad Written Language: 4.5 grade equivalent. Lastly, the results of the Behavior Assessment System for Children – Teacher Rating Scale provided the personality and behaviors observed. Appellant was rated in the At-Risk range with areas of concern as police involvement, academic underachievement, and disruptive behavioral problems.</p> <p>Appellant received another Educational Assessment on 2/6/2003 at the age of 18. Regarding his <u>Woodcock-Johnson Psycho-Educational Battery</u>, his scores were as follows Broad Reading: 5.6 grade equivalent (improved); Broad Math: 6.6 grade equivalent, and Broad Written Language: 4.9 grade equivalent. This report also indicates that</p>

		<p>Appellant could thrive in structured and consistent environment but continues to have poor peer interactions, poor adaptive functioning, and poor attendance.</p> <p>The final <u>Educational Evaluation</u> dated 11/30/2004, at the age of 19, indicates the need for Appellant to improve his school attendance because his academic performance was being negatively impacted. The new goal of “Andrew will improve writing, mechanics by developing editing strategies.” was created to address his deficient performance on assignments. Due to the ongoing attendance issues, Appellant was failing his classes and increasing in poor interpersonal interactions with adults and peers.</p> <p>This section concludes with the <u>final Psychological Evaluation by Naomi Carey</u>, Stanley G. Falk School Psychologist, on 4/21/2005, at the age of 19 and 10 months, which continued to indicate low average intelligence and low average and borderline skills in numerical reasoning, concentration, short –term auditory memory, and visual motor speed. Appellant was rated in the At-Risk range with areas of concern as police involvement, academic underachievement, and disruptive behavioral problems. Furthermore, this report was finalizing the graduation plan for June 2005.</p> <p>The Appellant struggled academically and with interpersonal relationships due to his behavioral, emotional, cognitive processing, and communication difficulties. It was consistently recommended that he needed 1:1 aid assistance and constant adult supervision. Additionally, it was reported that The Appellant’s peer interactions were verbally aggressive, sexualized, condescending and inappropriate. Despite his speech-language disorder, sexual trauma, incarceration, and multiple hospitalizations and school placements, he successfully passed RCT exams on Science, Math, US History and Government, Reading and Writing. He had ambitions to pursue employment in the computer profession. Unfortunately, 3 weeks before graduation, he withdrew from school to pursue employment at McDonalds and never obtained his diploma.</p>
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MEDICAL RECORDS

The Medical Records is a cross section of all the area hospitals that the Appellant has received treatment for various presenting issues. The importance of this section is that the Appellant has been given a plethora of diagnosis and treatment directions. This area is the first area that demonstrates the misinterpretation and miscommunications from professionals regarding diagnosis and treatment.

Concurrent to this, the Appellant's neurodevelopmental disorders prohibited him in deciphering which system and treatment direction he should pursue.

On the following pages are records that further link assessments to the conclusion the Applicant had a condition that qualified as immutable and debilitating condition affecting the central nervous system prior to the age of 22.

HOSPITAL	DATE	ISSUE	PHYSICIAN	DISCHARGE DIAGNOSIS
ERIE COUNTY MEDICAL CENTER ("ECMC")				Please note: Appellant has been presenting at this hospital for over 20 years. Childhood records were not released or available.
	11/1/2009 (age 24)	Comprehensive Psychiatric Emergency Program ("CPEP") – Presents with suicidal ideations.	Dr. Dham K. Gupta	Discharge ("DC") to home. Diagnosis ("dx") is Adjustment Reaction, Bipolar Disorder – Mixed, Other (ADHD , Impulse Control Disorder ("d/o")).
	2/6/2010 (age 24)	CPEP – presents as a 9.41 (involuntary transport/lethality issues)	Dr. Godzala (Resident) Dr. John Improta (Lead Psychiatrist)	DC dx is ADHD (by history), Bipolar d/o: Mixed (by impulse control d/o). Psychiatrist's summary – "... is an odd man, speaks in a slow, halting manner, almost appearing as if he has a pervasive developmental disorder, something along the autistic spectrum ".
	4/10/2010 (age 24)	- CPEP – presents as emergency admission under 9.41 of the Mental Hygiene Law - noncompliant with medication (e.g.: Lithium) due to weight gain and forgets to take medication	Dr. Godzala (Resident) Dr. John Improta (Lead Psychiatrist)	DC dx is Adjustment d/o with Disturb Conduct (Primary Axis I) and Learning Disability . He is linked to Dr. Wolin (psychiatrist) and recommends Lamictal or Abilify.

		-Police involvement occurred due to father/child argument.		
	7/20/2010 (age 25)	-CPEP – presents as 9.45 -Parent/child conflict regarding food intake. -threatening parents and fear of harm by mother. -swallowed multiple pills and signs of self-harm.	Dr. John Improtia (Lead Psychiatrist)	DC dx is Adjustment Reaction d/o: NOS (Not Other Specified), Bipolar d/o: NOS (by history) and Learning Disability (by history) . He was discharged to a shelter and mental health outpatient recommended.
	12/7/2011 (age 26)	-CPEP -9.41 -increased threats towards parents. -physical fight with brother.	Dr. Joshna Singh (Resident) Dr. Abiola Adelja (Lead Psychiatrist)	DC dx is Adjustment d/o with Disturb Conduct. He was discharged home and follow up with Horizon psychiatrist.
	10/15/2018 (age 33)	-CPEP Medical Screening for knee and ACL injury.	Ms.Kuldeep Mann FNP	Report indicates he has history of ASD , hypothyroidism, asthma and rotator cuff injury. He is medically cleared and sent to CPEP for Mental Health Assessment.
	10/15/2018 (age 33)	Presents at CPEP complaining of feeling depressed and describes his father is abusing him.	Dr. John Improtia (Lead Psychiatrist)	DC dx is ASD (Primary) and Depression (Secondary) . Parents report that...is unpredictable in behavior and demonstrated rocking back and forth and verbal abuse.
	11/24/2018 (age 33)	-CPEP 9.41 -Presents with suicidal ideations and	Dr. Samantha Salem (Resident) Dr. Tawni Frank	DC dx is Cluster B Personality d/o (Antisocial Personality Disorder) (Primary Axis I diagnosis). Secondary Diagnoses are Borderline Intellectual Functioning, Rule Out (“R/O”) cluster B personality disorder, R/O Opioid abuse and R/O Benzodiazepine abuse. Family history includes

		<p>homicidal threats toward parents.</p> <p>-He stated, "I was cooking food and I needed help." And "He reports that he needs his parents' assistance when cooking because "I've started fires before."</p>	(Lead psychiatrist)	<p>history of violence, threats with a knife, and fighting with sibling. Adult Protective Services are involved due to family dynamic (e.g.: There are claims that parents are abusing him.). Incontinence is documented with ... demanding diaper changes by staff.</p>
	<p>4/21/2019-5/5/2019 (age 33)</p>	<p>CPEP Medical screen and mental health admission due to stress, social situation, and inability to care for self.</p> <p>-Summary of diagnoses are Oppositional Defiance Disorder ("ODD")/Conduct Disorder (CO), ASD, Tourette's Syndrome, ADHD, mood disorder, and poor coping mechanisms.</p> <p>-Concerns regarding self-care</p> <p>-Hospital admission is related to social situation and neglect</p>	Varied doctors	<p>On 3/4/2019 Dr. Victoria Brooks (CPEP Psychiatrist) indicates "People with autism will engage in scripting behaviors, retreating into their own imaginary memory/state to defer to known topics, in a socially inept/inappropriate way, NOT otherwise reflective of a psychotic thought process. On exam here over an extended period, there is absolutely no evidence of psychotic thinking (no delusions, no hallucinations, no thought disorganization), but chronic problem-solving deficiencies. Additionally, there was a period of time here in CPEP this afternoon, when I witnessed the patient (without provocation, without audience), retreat to a quieter area of CPEP milieu, rocking and crying, grabbing his head and saying something to the effect of not being able to "take it," very clearly overstimulated and overwhelmed by hypersensitivity to sound/chaos surrounding him here in this environment and very consistent with autism."</p>

		of self-care as evidenced by chronic Hidradenitis suppurativa.		
	Continued: 4/21/2019-5/5/2019 (age 33)			On 4/21/2019, Dr. Jessica Grudzign (psychiatrist), dx is Neurodevelopmental d/o (Autism Spectrum d/o) as Primary Diagnosis is OCD. On 5/4/2019, Dr. Todd Kenneth (resident) indicates... uses weighted vest, hearing protection to limit loud noise, and limited lights due to sensitivity. Final DC dx is ADHD, and Personality Disorder, NOS.
	8/6/2019 (age 34)	-CPEP 9.41 transfer from Sister's Hospital and admitted for social admissions. -Social admission was justified because he is banned from homeless shelters, hotels, failure of all external placements, and returning to his parents.	Dr. Ralph Benedict (Psychologist)	During the social admissions, a neuropsychological consult was requested. Dr. Benedict reports a) he may have neuropsychiatric disorders (e.g.: OCD, Tourette's or ASD) and personality disorder.
	12/8/2019 (age 34)	Volunteer presentation at CPEP for depression and suicidal ideations.	Dr. Balwant Nagra (psychiatrist)	DC dx is neurodevelopmental – ASD diagnosis, Tourette's Disorder, ADHD, Bipolar by history.
	2/5/2020 (age 34)	-CPEP – 9.41 following his 2/3/2020 discharge from CPEP. -Primary admission was for running into traffic and	Dr. Victoria Brooks (psychiatrist)	...reports being inconsistent with medications and outpatient treatments. There are claims that ... sabotages his housing options. There are concerns of negative outcomes due to his threats of self-harm and injurious gestures.

		wandering without a coat. -Was removed from a shelter in Niagara county		
KENMORE MERCY HOSPITAL				
	4/29/2020 (age 34)	Inpatient Psychiatric Consultation	Dr.Naureen Jaffri (Psychiatrist)	The reason for consultation is for capacity regarding living independently. There are indications of inability to care for self by being involved with Erie County Department of Social Services and Adult Protective Services. He has difficulty with over stimulations and feelings of being overwhelmed. Dx is Anxiety, OCD, history of auditory sensory processing disorder. It was identified that ... does not have capacity for managing finances, treatment, and with basic ADLs. ; b) He will need supervised living situation with OT and nursing.; c) SPOA referral is recommended for psychiatric supports. And d) APS should obtain guardianship to assist ...
	5/1/2020-5/5/2020 (age 34)	-Concerns that ... is banned from housing options	Dr. Craig Fetterman (Internal Medicine Specialist)	DC dx is ASD, Mixed Anxiety Depressive Disorder. Record indicates ongoing barriers for housing (e.g.: violent history, unable to administer medication, complete ADLs, and chronic incontinence issues).
	5/6/2020 (age 34)	Further data collected for record for discharge summary. Consumer presented with anxiety.	Dr. Frederick Morey (Internal Medicine Specialist)	Dx is ASD, Mixed Anxiety Depressive Disorder, Diabetes Mellitus Type 2 in Obese, and Hypothyroidism
NIAGARA FALLS	7/31/2020 (age 35)	Presents with depression.	Dr. Courtenay Watt	DC dx is Generalized Anxiety Disorder, Adult.

MEMORIAL MEDICAL CENTER “NPMC”			(Emergency Medicine Specialist)	
MOUNT ST. MARY’S HOSPITAL AND HEALTH CENTER	3/15/2020 (age 34)	Presents with head injury.	Dr. Sly (Internal Medicine Specialist)	There are concerns about the... ability to care for self, due to autism. Partial dx is Autistic Disorder, Major Depressive Disorder, Single Episode, Unspecified, Anxiety Disorder, Unspecified, Hypothyroidism, Unspecified, and Type 2 Diabetes Mellitus Without Complications.
SISTERS OF CHARITY (“Sister’s Hospital”)	6/21/2019-6/23/2019 (age 34)	Presents with abdominal pains.	Dr. Jacqueline Heim (Family Medicine Specialist)	Dx dx is Autism, Diabetes Mellitus, Type 2 and Hypothyroidism. He was admitted for social situation.

It is clear from a review of the Medical Records section, that Appellant has been evaluated in multiple hospitals settings by a multitude of physicians and psychiatrists. There is not any consistent diagnosis, except that his several neurodevelopmental orders were reported repeatedly, early and persistently. There were many instances where Appellant’s behaviors and responses were given a diagnosis of ASD. In addition, throughout the medical history, the records indicted Appellant had many other medical symptoms highly correlated with ASD such as Type 2 Diabetes and Hypothyroidism, and other co-occurring neurodevelopmental disorders such as ADHD, Tourette’s, Learning Disabilities, and Conduct Disorders.

MENTAL HEALTH RECORDS

The Mental Health Records are a cross section of adult mental health area clinics that the Appellant received treatment for various presenting issues. The importance of this section is that the Agency refers to the Appellant’s mental health as the primary reason for his behaviors and dismisses the fact that Asperger’s/Autism Spectrum Disorder was present throughout the Appellant’s life span. Historically, the Appellant has been given a plethora of diagnosis and treatment directions by multiple mental health professionals who narrowly focused their attention on stabilizing the trauma and not recognizing the ASD characteristics and diagnosis.

During the Appellant's childhood and adolescent developmental stages (1988-2006), there are multiple identifiable characteristics of ASD, neurodevelopmental disorders (e.g.: ADHD, Learning Disorders, and Conduct Disorders/Oppositional Defiance Disorder), neuropsychiatric disorders (e.g.: Cognitive Deficit Disorders, Major Depression Disorder, General Anxiety Disorder, and Attention Deficit Disorder), and neurological diseases.

Furthermore, if during the Appellant's early childhood, the DSM-III and DSM-IV allowed mental health provider to diagnosed ASD comorbidly with certain mental health diagnosis, then the Appellant's diagnosis of Neurodevelopmental Disorders such as Receptive and Expressive Speech and Language Disorder, Tourette's, Central Auditory Processing Disorder would have been recognized a symptoms and characteristics of ASD, and he would have been diagnosed with ASD and multiple comorbid diagnoses such as PTSD, ADHD, General Anxiety Disorder, and Major Depression Disorder during this period. It is not until 2013 with the establishment of the DSM-5 that the Appellant who is age 28 can have the co-occurring diagnoses of ASD with mental health disorders. The Appellant exemplifies an extraordinarily complex manifestation of neurodevelopmental disabilities and mental health disorders.

MENTAL HEALTH RECORD	DATE	PROFESSIONAL NAME	Comments	MENTAL HEALTH RECORD COMMENTS
HORIZONS HUMAN HEALTH SERVICES ("Horizons")	10/8/2008 Diagnostic Review (age 23)	Colleen Strasser (Social Worker)		Given Depressive Disorder NOS on 11/16/2004.
	11/11/2008 Psychiatric Evaluation Referral Form (age 23)	Colleen Strasser (Social Worker)		Has a history of Schizoaffective Disorder and dysthymia since 1988 (age 3)
	11/11/2008 (age 23)	Dr. Arana Belito (psychiatrist)		Given Mood Disorder, NOS, Rule Out Bipolar, Obsessive-Compulsive disorder (by history), Tourette's Disorder (by history), ADHD
	11/20/2008	Colleen Strasser (Social Worker)		Given Depressive Disorder NOS

	Progress note (age 23)			
	1/28/2009 Progress note (age 23)	Colleen Strasser (Social Worker)	-mother discloses learning disabilities and cognitive problems	
	7/21/2009 Doctor's note (age 24)	Dr. Richard Wolin (psychiatrist)		Given Depressive Disorder, NOS, R/O Schizoaffective disorder, and R/O Bipolar Disorder
	9/9/2009 Progress note (age 24)	Colleen Strasser (Social Worker)	-Preliminary discussion regarding ASD	
	11/16/2009 Doctor's progress note (age 24)	Dr. Richard Wolin (psychiatrist)	-Mild ASD noted -Asperger diagnosis was given by history	Given Depressive Disorder, NOS, R/O Schizoaffective Disorder and R/O Bipolar Disorder
	2/16/2010 Doctor's progress note (age 24)			Given Depressive Disorder NOS on 11/16/2004.
	4/14/2010 Doctor's progress note	Dr. Richard Wolin (psychiatrist)	-May have Tourette's and ASD	Given Depressive Disorder, NOS, R/O schizoaffective disorder, and R/O Bipolar Disorder

	(age 24)			
	11/8/2010 Doctor's progress note (age 24)	Dr. Richard Wolin (psychiatrist)		Given Depressive Disorder, NOS, R/O schizoaffective disorder, and R/O Bipolar Disorder
	2/22/2011 Doctor's progress note (age 24)	Katie Millard (nurse practitioner)		Given Depressive Disorder, NOS on 11/16/2004, and R/O schizoaffective disorder on 4/22/10.
	12/06/2011 Doctor's progress note (age 25)	Katie Millard (nurse practitioner)		Given Depressive Disorder, NOS on 11/16/2004, and 4/22/2010.
	9/10/2012 Doctor's progress note (age 26)	Dr. Richard Wolin (psychiatrist)		Given Depressive Disorder, NOS, R/O schizoaffective disorder, and R/O Bipolar Disorder
	11/07/2012 Diagnostic Review (age 26)	Raymond Lorigo (Licensed Social Worker)		Given Schizoaffective Disorder
	11/25/2013 MD/NP Service Note (age 27)	Dr. Richard Wolin (psychiatrist)		Given Depressive disorder, NOS; R/O Schizoaffective Disorder; R/O Bipolar, and Provisional Diagnosis of Tourette's syndrome

	7/14/2014 MD/NP Service Note (age 28)	Dr. Richard Wolin (psychiatrist)	Given R/O Autism	Given Depressive disorder, NOS; R/O Schizoaffective Disorder; R/O Bipolar, and Provisional Diagnosis of Tourette's syndrome
	1/7/2015 Diagnosis Review (age 28)	Katie Millard (nurse practitioner)	ASD traits of Depressive Type, R/O Bipolar Type, Gille de la Tourette Syndrome	Given Schizoaffective Disorder on 4/22/2010 and Tourette's Disorder on 7/14/2014
	11/28/2016 Diagnosis Review (age 29)	Dr. Richard Wolin (psychiatrist)	Dr. Wolin notes that there are Asperger components present.	Given Schizoaffective Disorder, Bipolar Type on 9/4/2015 and Tourette's Disorder on 9/4/2015.
	8/28/2017 Diagnosis Review (age 30)	Dr. Richard Wolin (psychiatrist)	Dr. Wolin notified that a neuropsychologic al evaluation occurred. There are suggestions the Appellant had components of ASD.	Given Schizoaffective Disorder, Bipolar Type on 9/4/2015 and Tourette's Disorder on 9/4/2015.
	12/04/2017 Diagnosis Review (age 30)	Dr. Richard Wolin (psychiatrist)		Dr. Wolin stated "he appears to have a schizoaffective disorder as well as an ASD well have ADD which is contributing to concentration focus attention and short-term memory. "

	4/16/2018 Outpatient Case Review Form (age 30)	Alicia Coulter (Licensed social worker)		Given ASD on 10/9/2017, Schizoaffective Disorder, Bipolar Type on 9/4/2015 and Tourette's Disorder on 9/4/2015 .
	8/7/2018 Mental Health Discharge Summary (age 31)	Amber Blanchard (Licensed social worker)	Given ASD on 10/9/2017	Given Tourette's disorder on 9/4/2015 According to her report, Dr. Wolin changed dx to ASD in 10/2017 and removed schizoaffective d/o as of 7/2018 due to believing that Autism is the primary dx.
CHILD AND FAMILY SERVICES	8/3/2018 Diagnostic Review (age 33)	Katie Jafari (Licensed Social Worker)	R/O Asperger's	Given Unspecified bipolar and related disorder and Narcissistic Personality Disorder on 8/3/2018. R/O Bipolar
	12/7/2018 Discharge Summary (age 33)	Katie Jafari (Licensed Social Worker)		Given Unspecified bipolar and related disorder on 8/3/2018. Given Unspecified personality disorder on 11/7/2018.
	8/4/2020 thru 9/2/2020 Treatment Plan (age 35)	Jennifer Dixon (CD Counselor Certified Alcohol & Substance Abuse)	Continue with the diagnosis of ASD .	Continue with Unspecified anxiety disorder. -Homelessness and emotional management are primary goals
	9/2/2020 Discharge Summary (age 35)	Jennifer Dixon (CD Counselor Certified Alcohol & Substance Abuse)	DX dc is ASD .	DX dc is Unspecified anxiety disorder.

ASSESSMENT EVALUATIONS AND RECORDS

The Appellant has participated in an extensive and unnecessary number of neuropsychological evaluations. Ordinarily, an individual would undergo 1 neuropsychological evaluation ever 2-3 years. Appellant completed a total of 13 re-evaluations and evaluations with 5 different neuropsychologists, neurologists, and psychologists in 6 years. (e.g.: Dr. David Lichter: childhood – present; Dr. Santamaria 8/17/2017; 11/6/2018; and 11/12/2018; Dr. Ralph Benedict – 4/23/20019; Dr. Justin Naylor – 11/19/2019 and 1/21/2020; and Dr. Paul Kopfer – 10/27/2020, 11/03/2020, 12/1/2020, 7/28/2021, and 8/5/2021). Professional practice is to concede to the most recent evaluation, yet DDRSO and OPWDD denial of eligibility letters have indicated preferences to pieces of previous reports to justify denial, attributing his condition to psychiatric disorders, as opposed to accepting the total of reports documenting several early and repeated neurodevelopmental disorders.

NAME	DATE	OUTCOME
Dr. David Lichter (Neurologist who treated him since 2001)	2/27/2017	Dr. Lichter indicated that the purpose of the appointment of the same date was for the follow up review of a tic disorder, possible ASD, and mood liability. Dr. Lichter stated that Appellant had supportive clinical features that are demonstrated in ASD such as arm flapping, long-standing focused interest in weather, computers, and electronics, difficulty with maintaining friendships, problems with eye contact (by history), learning disabilities in spelling, reading and listening comprehension.
	7/29/2019	The Appellant had another follow up appointment for the review of his mild residual tic disorder, stereotypes, ASD, and mood liability. Dr. Lichter reports that Appellant exhibited minor eye tics, poor eye contact, arm flapping movement, long standing focus interest (e.g.: weather, computers, and electronics), and minor sniffing. Additionally, his rocking movements in childhood and tendency to play unusually with toys have historically suggested ASD. Due to conflicting diagnoses, Dr. Lichter decided another neuropsychological evaluation of Appellant was appropriate
	1/13/2020	The Appellant and he was accompanied by a staff member from Community Mission. During this period, Appellant resided in a homeless shelter due to ongoing inability to take care of himself. Dr. Lichter stated that Appellant exhibited frequent stereotypies of ASD in “the form of “stimming” movements performed with the hands, particularly the fingers and hand on the left side”. (Addendum Assessment Section) Medication was recommended to assist with the management of cognitive attention, motor restlessness, sensory symptoms, and Dr. Lichter’s

		diagnoses were Chronic motor and vocal tic disorder, Autistic Disorder, Attention-deficit hyperactivity disorder, unspecified type, and Developmental disorder of scholastic skills, unspecified.
	11/2/2020	The Appellant had another follow up appointment for the review of ASD, stereotypies, and chronic tic disorder. Dr. Lichter reported his observation: “Andrew exhibited repetitive constant stereotypic tapping movements of the right hand against his knees as well as similar repetitive movements of the left hand.”. Dr. Lichter’s observations coincide with the typical characteristics of ASD. In the Impression/Plan section, Dr. Lichter states “Andrew continues to experience significant anxiety associated with his tic disorder and autistic spectrum disorder which appears to have been driving some of his stereotypies as well as his tics recently, including appearing to aggravate simple vocal tics.”.
Dr. Ralph Benedict	4/23/19	The Appellant was hospitalized at ECMC (Erie County Medical Center) and a neuropsychological consult was requested once again due to conflicting diagnosis. Dr. Ralph Benedict provided the neurological consult again due to conflicting diagnosis. He was given a copy of Dr. Santamaria’s report where Santamaria had diagnosed Appellant with cognitive and behavior issues. Horizon had separately labeled Appellant with Tourette’s Disorder (9/14/2015) and ASD (10/9/17). Through Dr. Benedict’s interview process, he concluded he was unable to clearly dispel or determine ASD and Tourette’s Syndrome without evidence of prior testing results or reports or dispel or determine whether Appellant had ASD due to the lack of childhood records and medical records.
Dr. Naylor	11/19/2019	<p>The <u>NIH Toolbox Emotion Domain and the Social Communication Questionnaire</u> were completed. Dr. Naylor reports the following: Parents verify symptoms of ASD in early childhood; that Appellant had speech and language deficits and limited peer interactions due to speech and language deficits. On 1/21/2020, Appellant returned to Dr. Naylor for an evaluation to determine Autism. During this evaluation, Dr. Naylor interviewed Appellant’s parents and family friend for historical reporting on behaviors during childhood and adolescents.</p> <p>When Dr. Naylor interviewed Appellant’s parents, they had indicated “that Andrew received speech therapy, developmental testing, and special education. Regarding early development, parents noted that it was delayed. Parents provided additional information regarding Andrew’s repetitive behavior. They noted that he engaged in rocking and preoccupied with spinning. I / (Dr. Naylor) sought more information as to why the symptoms of Autism were not described in his high school psychoeducational report. His parents indicated that Andrew “fell through the cracks””. (Addendum Assessment Section Page X) Parents further specified that they discussed their concerns about the Autism symptoms with teachers and health care providers as well.</p>

		<p>Dr. Naylor administers the <u>Autism Diagnostic Observation Schedule – Second Edition (“ADOS-2”), and Adult Behavioral Checklist for Ages 18-59</u>. ADOS-2, an observational assessment used to diagnose Autism. The ADOS-2 total score for Module 4, was 13 (Communication Total score was 4 and Social Interaction Tool is 9). The score of 13 indicates the Autism Classification and exceeds the Autism cutoff score of 10 and higher. Dr. Naylor also captured stereo typical and idiosyncratic characteristics of Autism such as speech abnormalities (e.g.: Appellant utilized the objective pronoun of “me” when he referred to himself and a DSM diagnostic consult needs to occur to verify disorders.</p> <p>Dr. Naylor’s clinical interpretation was inconclusive and according to the documentation, Dr. Naylor’s attributes his inability to determine ASD and mental health disorders due to the “excessive contamination of the evaluation by the significant number of emails, texts, and phone calls” from Appellant himself (Addendum Assessment Section).</p>
Dr. Paul Koper (Part I)	10/27/2020 11/3/2020 12/1/2020	<p>Dr. Koper’s report indicates the following:</p> <p>a) On the <u>Social Communication Questionnaire (“SCO”)</u>, an assessment of symptoms of ASD with the 3 main categories (e.g.: deficiencies in communication, deficiencies in reciprocal social interaction, and the presence of repetitive, restrictive, or stereotypical behaviors that interfere with daily functioning) and Appellant scored 21 which is above the cut-off score of 15. The score of 21 indicates ASD.</p> <p>b) The Appellant has abnormalities in his communication with odd phrases, utterances, neologism/made up words, pronoun reversals, and inappropriate comments or questions.</p> <p>c) The <u>Social Responsiveness Scale – Second Edition (“SRS-2”)</u>, an assessment tool that evaluates a self-report form and an observer form. Appellant scored > 90 and the observer/ this writer scored 88. These scores show a severe range of deficiencies in reciprocal social behaviors and are “strongly associated with clinical diagnosis of ASD.” Additionally, the SRS-2 also showed that he suffered from a disability in the severe range for restricted interests and repetitive behaviors.</p> <p>d) The Childhood Autism Rating Scale 2 (“CARS-2”) High Functioning Version also measures frequency of Autistic behaviors as reported by parents. Appellant T-score of >70 shows severe symptoms of ASD. Appellant also represented impairments in social/emotional understanding, relating to people, verbal and non-verbal, communication, understand language and words, emotional regulations, changes in routine, and sensory aversion.</p>

		<p>e) The Adult Asperger's Assessment, an assessment to find Asperger/High Functioning Autism, has 2 checklists, Autism Spectrum Quotient ("AQ") and Empathy Quotient ("EQ"). On the AQ, Appellant scored a 47 is above the cut-off of 32 and shows Autism. Additionally, Appellant's score of 19 on the EQ indicates Autism as well.</p> <p>f) The Repetitive Behavior Questionnaire, an assessment which focuses on repetitive sensory and sensory motive behavior, which was also completed by Dr. Naylor, indicated that The Appellant's score fell within range for the Autistic sample; and</p> <p>g) The Adaptive Behavior Assessment System-Third Edition (ABAS-III) Adult Form, a standardization measure of independent living skills, was completed by Mrs. Ditch. ABAS-III has 2 components, General Adaptive Composite ("GAC") and Adaptive Doman Composite ("ADC"). The GAC score is 61 and falls in the extremely low range. Furthermore, the ADC also falls in this range. Both scores indicate deficiencies in adaptive functioning and implies "the need for substantial support and assistance." (Addendum Assessment Section)</p> <p>Within Dr. Kopfer's summary section, he acknowledges "the co-occurring issues of mental health issues and ASD and that ASD a separate condition and one that had an ob adverse impact on his adjustment difficulties" (Addendum Assessment Section) It was the opinion of Dr. Kopfer that ASD is present, and that Appellant has a significant history of adaptive function deficits.</p>
Dr. Paul Kopfer (Part II)	7/28/2021 8/5/2021	<p>Dr. Kopfer's reports the following findings:</p> <p>a) He reviews Dr. Lichter's reports and determines that the finding of ASD, Tourette's, and Anxiety have been longstanding. He identified that the Appellant has had his ASD treated with Memantine by Lichter.</p> <p>b) Dr. Wolin over ten years of treating the Appellant diagnosed him with ASD and Tourette's and removed the Schizoaffective Disorder.</p> <p>c) Dr. Naylor indicated that ASD symptoms were present in Appellant's childhood (eg: 1) speech and language deficits, 2)at 2 years old language difficulties, and 3)did not talk much in complete sentences until 9 years old) as evidence by parental/mother reporting. Dr. Naylor administers the ADOS-2 and the combined score of Communication and Social Interactions was 13, which exceeds the Autism classification cut-off of 10. The Social Communication Questionnaire score is 20 and exceeds the established cut-off score of 15.</p>

	<p>d) <u>Dr. Santa Maria</u> administered 2 Autism measures (eg: The Social Communication Questionnaire and the Childhood Autism Rating Scale) and the resulting scores fell within a positive range for Autism. However, he maintained these results as secondary to Schizopffective Disorder, Depressive Type.</p> <p>e) <u>Dr. Ralph Benedict</u> “was also unable to render a diagnosis of ASD due the absence of reliable history and confidence in patient’s report of symptoms.....While he acknowledges that Andrew may have had a childhood onset disorder, such as ASD, he did not have enough information to say so with certainty.</p> <p>f) “Autistic features may have been present which could underlie and hinder his adjustment, his behavior and emotional symptoms were given priority by service providers.”</p> <p>g) “Psychometric test results from 3 separate examiners show consistent score profiles that fall withing the significant range for Autism. A number of providers have identified ASD as a primary or secondary diagnosis... Dr. Wolin had changed Andrew’s diagnosis to ASD and Dr. Lichter has concurred with this diagnosis ... Andrew shows a number of symptoms in the restricted, repetitive, and stereotypical behavior group (for example, unusual hand and body mannerism, sensory preference and aversions, resistance to change, “insistence on sameness”), the presence of which often is informative in discriminating ASD from other conditions. “</p> <p>h) “Research has shown that individuals with ASD have a relatively high rate of comorbid conditions. Compared with their neurotypical peers, it has been found that ASD individuals may be more that five times as likely to have received at least one psychiatric diagnosis and are also more likely to have visited a psychiatrist or emergency ER services for psychiatric reason.....upwards of 90% of children/adolescents with Autism also meet criteria for another psychiatric disorder and have multiple (three or more) diagnoses.....Anxiety, depression, and OCD appear to be the most frequently occurring diagnosis. Presentation of symptoms related to these conditions may lead to diagnostic overshadowing in the Autistic symptoms may be interpreted as part of the psychiatric condition and not a separate condition.”</p> <p><u>i)Autism Diagnostic Interview -Review (ADI-R)</u>, an instrument recommended by OPWDD, was completed with Mrs. Janet Ditch (mother) on 8/5/2021. The ADI-R is organized in 3 symptoms group that are consistent with current DSM criteria. All scores exceeded the cut offs: Qualitative Abnormalities in Reciprocal Social Interaction - Score is 19 with a cut off of 10. Qualitative Abnormalities in Communication – Score is 18 with a cut off of 8.</p>
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		<p>Restricted, Repetitive, and Stereotyped Patterns of Behavior – Score is 8 with a cut off of 3.</p> <p>j) Parental interview indicates speech delays and inability to form sentence structures. His days placed in a Language Development Program for 4 year. He had a number of language anomalies and social communication was also delayed and one sided. He struggled with comprehending what others were saying. There was an inability to make eye contact and follow social cues.</p> <p>l) “Andrew shows significant deficits in adaptive skills, and his measured abilities fall well below expected levels considering his age and cognitive functioning. It is also clear that his adaptive deficits were present at a young age due to his prolonged language deficits, Tourette’s, and social/interpersonal difficulties. Deficits in communication/conversational abilities, interpersonal, and social functioning, and overall self-management may be considered as more reflective of an Autism Disorder than a mental health condition.</p> <p>Dr. Kopfer verifies that the additional evidence submitted demonstrated symptoms of Autism were evident during Andrew’s developmental years and are supportive of a diagnosis of ASD.</p>
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OPWDD ELIGIBILITY CRITERIA

This chart captures the criteria of a developmental disability as defined in Mental Hygiene Law 1.03(22) and how the Agency had all the information to determine eligibility and continued to deny the Appellant. The Agency acted in BAD FAITH. The Appellant has provided verification, additional documents, and evaluations for over 3 years.

OPWDD REQUIREMENTS	VERIFICATION
1. An established Qualifying Diagnosis. Qualifying diagnosis include Autism Spectrum Disorder, Intellectual Disability, Cerebral Palsy, Epilepsy, Prader Willi, Familial Dysautonomia and other neurological impairments (injury malformation, or disease of the brain and/or spinal cord).	<p>a) The Appellant was designated by the Social Security Administration with a Neurodevelopmental Disorder and Learning Disabled in child. The Appellant received SSI benefits from July 1, 1992 to 1998.</p> <p>b) By the age of 3, the Appellant presented with a speech and language disorder and eventually placed at the Language Development Program.</p> <p>c) By the age of 6, the Appellant begins his 30 year treatment of Tourette’s Syndrome with Dr. Lichter.</p> <p>d)The Appellant also received a diagnosis of ADHD which is also an organic neurological impairment.</p>

2. The disability must have occurred prior to age 22.	The record clearly indicates that the qualifying diagnosis was present in early childhood to present.
3) There must be a likelihood that the condition will continue indefinitely.	The Appellant has childhood determination of the neurological impairments and neuropsychiatric diagnosis. The most compelling documentation is that a neurologist, Dr. Lichter, has treated the Appellant for 30 years and will continue to treat the Appellant for ASD, Tourette's.
4)The disability must constitute a substantial handicap to the individual's ability to function normally in society. The deficit in performance must be clearly linked to the identified disability, not merely co-occurring.	<p>a) Education Records indicate the cognitive processing issues, adaptive behavioral functioning, and learning disability through assessments such as Woodcock Johnson Psycho-Educational Battery, and the Behavioral Assessment for Children-Teacher Rating Scale.</p> <p>b) The Mixed Expressive and Receptive Speech and Language Disorder, Tourette's Syndrome, ADHD, and ASD created impairments in academics, interpersonal relationships with peers, community participation, and with his family.</p> <p>c) The Appellant had multiple hospitalizations and encounters with law enforcement due to his inability to process system expectations.</p> <p>d) The Agency is required to examine the relationship between the central nervous system disorders with the respect to the effects upon an individual's intellectual and adaptive functioning. The Agency minimized of years Special Education Services and the extensive assessments that establish the Appellants deficits.</p>
AUTISM SPECTRUM CHECKLIST	
1)Assesment of Adaptive Behavior Functioning (Completed within the past 12 months. (Vineland-3 using comprehensive form or ABAS-3; Abbreviated or brief measures are not acceptable.)	In the 12/10/2021 report, Dr. Kopfer completed this assessment, and his findings were: Adaptive Behavior Assessment System-Third Edition (ABAS-III) Adult Form ABAS-III has 2 components, General Adaptive Composite ("GAC") and Adaptive Doman Composite ("ADC"). The GAC score is 61 and falls in the extremely low range. Furthermore, the ADC also falls in this range. Both scores indicate deficiencies in adaptive functioning and implies "the need for substantial support and assistance."
2)An updated social history, psychosocial report, or other background report within the past 12 months.	Dr. Kopfer and multiple psychologists gathered information about childhood. This requirement was completed.
3)A Retrospective Adaptive Interview regarding functioning prior to age 22.	Renee Jackson, (Prime Care Supervisor) completed these criteria. The Retrospective Report was included in the evidence packet from 4/27/2021.
4)A Comprehensive Autism Evaluation must include"	a)Dr. Kopfer administered the ADI – R and the results indicate ASD. Autism Diagnostic Interview -Review (ADI-R) , was completed with Mrs. Janet Ditch (mother) on 8/5/2021. The

<p>a) An interview using a measure based on early developmental history such as the Autism Diagnostic Interview Revised (ADI-R) or the Social Communication Questionnaire (SCQ).</p> <p>b) An autism-specific measure that involves direct observation of the individual (the Autism Diagnostic Observation Schedule -ADOS-2- is preferred but the Childhood Autism Rating Scale – CARS-2 – is also acceptable) (it can't just be a screening, or a checklist handed to someone to fill out).</p> <p>c) Report must include a good developmental history, including information about developmental milestones, repetitive behaviors, preoccupations, social interactions, friendships, etc..</p> <p>d) Report must also include an observation section that describes in detail the individual's behavior during the evaluation.</p> <p>e) A narrative report indicating that the individual's adaptive deficits arise from autism-related behaviors (eg: the person doesn't brush his teeth on daily basis because he doesn't seem aware its not socially acceptable to have bad breath, or because he doesn't like the "feel" of the toothbrush – not just because he is oppositional and refuses everything his parents tell him to do)</p> <p>f) A differential diagnosis between autism and other developmental disorders (eg: Social Communication Disorder) and/ or diagnosed mental health concerns. It must clearly list characteristics for ASD that have been observed, and must indicate which adaptive</p>	<p>ADI-R is organized in 3 symptoms group that are consistent with current DSM criteria. All scores exceeded the cut offs:</p> <p>Qualitative Abnormalities in Reciprocal Social Interaction - Score is 19 with a cut off of 10.</p> <p>Qualitative Abnormalities in Communication – Score is 18 with a cut off of 8.</p> <p>Restricted, Repetitive, and Stereotyped Patterns of Behavior – Score is 8 with a cut off of 3.</p> <p>b) Dr. Kopfer, Dr. Naylor, and Dr. Santa Maria administered SCQ and the results indicate ASD. The findings from <u>Dr. Kopfer's</u> report are:</p> <p>On the Social Communication Questionnaire ("SCQ"), an assessment of symptoms of ASD with the 3 main categories (e.g.: deficiencies in communication, deficiencies in reciprocal social interaction, and the presence of repetitive, restrictive, or stereotypical behaviors that interfere with daily functioning) and Appellant scored 21 which is above the cut-off score of 15. The score of 21 indicates ASD.</p> <p>The findings from Dr. Santa Maria's report indicates:</p> <p>The Social Communication Questionnaire and the Childhood Autism Rating Scale) and the resulting scores fell within a positive range for Autism.</p> <p>The findings from Dr. Naylor's report indicates:</p> <p>Dr. Naylor administers the Communication and Social The Social Communication Questionnaire and score is 20 and exceeds the established cut-off score of 15.</p> <p>c) Dr. Naylor administers the Autism Diagnostic Observation Schedule – Second Edition ("ADOS-2"), and Adult Behavioral Checklist for Ages 18-59. ADOS-2, an observational assessment used to diagnose Autism. The ADOS-2 total score for Module 4, was 13 (Communication Total score was 4 and Social Interaction Tool is 9.). The score of 13 indicates the Autism Classification and exceeds the Autism cutoff score of 10 and higher. Dr. Naylor also captured stereo typical and idiosyncratic characteristics of Autism such as speech abnormalities (e.g.: Appellant utilized the objective pronoun of "me" when he referred to himself and a DSM diagnostic consult needs to occur to verify disorders.</p>
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deficits arise from ASD, and which arise from other diagnoses.	<p>d)Dr. Kopfer administered the Childhood Autism Rating Scale 2 (“CARS-2”) High Functioning Version also measures frequency of Autistic behaviors as reported by parents. Appellant T-score of >70 shows severe symptoms of ASD. Appellant also represented impairments in social/emotional understanding, relating to people, verbal and non-verbal, communication, understand language and words, emotional regulations, changes in routine, and sensory aversion.</p> <p>e)Each neuropsychological report captures a developmental review of milestones.</p> <p>f)Dr. Kopfer addresses the relationship between mental health and ASD in his Part II report.</p>
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CONCLUSION

After of a review of the clinical and historical records, there is ample evidence that indicates neurodevelopmental disorders involving the central nervous system (e.g., ASD, ADHD, Expressive Language Disorder and Tourette’s Syndrome) have been present in the Appellant’s lifespan. The combinations of these conditions have not only impacted brain functioning and cognitive processing, but also has created instability in psychological and medical disorders. Appellant’s neurodevelopmental disorders were present at birth and symptoms of ASD were initially observable, recognized, and noted by professionals.

During early childhood, the records indicate that Appellant exhibited a substantial symptoms of ASD and the diagnosis of Tourette’s as evidenced by Dr. Lichter’s 30 year treatment and monitoring of the Appellant and his recognition of his cognitive processing and speech impairments, and difficulties with social communication and interactions. His brain and neurological dysfunction and deficits were also indicated in Educational and Mental Health Records as well. The educational documentation indicates that The Appellant had cognitive impairments prior to the onset of mental health issues. Dr. Wolin’s 10 year treatment and psychiatric monitoring of the Appellant also determined the diagnosis of Autism and Tourette’s in accordance with the DSM -5. Lastly, Dr. Naylor, Dr. Santa Maria, and Dr. Kopfer both administer multiple assessments which confirms severe ASD and severe deficits in the adaptive behavioral functioning areas.

Appellant has had a qualifying diagnosis of Tourette’s Syndrome and Autism Spectrum Disorder since an early age that has been obscure at times, but never superseded by the symptoms of his other psychological and behavioral problems. Tourette’s Syndrome

and ASD are an intricate part of the Appellant's existence. The Appellant has provided medical documentation regarding the occurrence of both diagnoses. He established his developmental disability has occurred for 36 years and would continue indefinitely. Additionally, his repeated problems with law enforcement, mental health officials, and inability to maintain a residence clearly established his inability to function normally in society without OPWDD services.

The Agency refused to recognize this and have not extend him OPWDD services. Thus, The Appellant has been insufficiently treated in other systems such as Special Education, Mental Health, and Legal System, which has further impaired his developmental and achievement level. Furthermore, he was unable to fully achieve his intellectual capabilities, stable social emotional management, and adequate daily living skills because he was denied access to supports and services from the OPWDD system.

In summary, there is sufficient evidence from early childhood thru adulthood for the Appellant to be determined as a developmentally disabled, with both a host of neurological conditions involving the central nervous system, and mental illness. It is respectfully requested that the ruling be reversed because the Appellant does have multiple qualifying diagnosis and substantial qualifying handicaps, attributed to the qualifying conditions. The Appellant has met the criteria for developmental disabilities and eligibility into the OPWDD system has been established. Ultimately, the Appellant needs the essential services available from OPWDD to ensure his overall health and safety and to become an independent individual thriving in the community

Respectfully submitted,
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NY Connects Outreach Specialist

Date: September 28, 2021